

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07521/90
Reg. Dist. No.

07523

1. PLACE OF DEATH a. COUNTY Howard MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waterloo c. LENGTH OF STAY IN 1b Rt. 1 and 175 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 1 and 175				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE N.Y. b. COUNTY Erie c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Buffalo 69X-3 d. STREET ADDRESS 599 N. Division St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;"> First Middle Last </div> ROLAND (ROLON) CANNON				4. DATE OF DEATH <div style="display: flex; justify-content: space-between;"> Month Day Year </div> 7-30-57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 3-17-1907		9. AGE (In years last birthday) 50 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer			
11. BIRTHPLACE (State or foreign country) Effingham S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ben Cannon			
14. MOTHER'S MAIDEN NAME Lizzie Evans		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-24-2904			
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Skull Fractures, laceration of brain DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe contusion of chest					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> Car traveling S. Rt. 1 made left turn in front of tractor-trailer					
20c. TIME OF INJURY Month, Day, Year 12.20 AM 7-30-57 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway			
20f. (City or town) Waterloo		(County) Howard		(State) Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Charles S. Whitaker</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-30-57			
EXAMINER'S NAME (Type) Charles S. Whitaker		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8/2/1957		22c. NAME OF CEMETERY OR CREMATORY Buffalo			
22d. LOCATION (City, town, or county) New York		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Isaiah L. Brown & Son		ADDRESS 108 W. Montgomery St.		24a. REC'D BY REGISTRAR AUG 6 1957			
Balto, Md		24b. REGISTRAR'S SIGNATURE <i>E. Bird Williams</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

AUG 6 1957

BUREAU V. S.

07522

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenwood		c. LENGTH OF STAY IN Ib		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenwood			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY GARLAND		First Middle Last Clar K		4. DATE OF DEATH July 18 1957		Month Day Year	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 18, 1875	
9. AGE (In years last birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James H. Clark				14. MOTHER'S MAIDEN NAME Lavenia Dorsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Howard W. Clark		Address Glenelg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis-Nephritis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 days Months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February, 1955 , to July 16, 1957 , that I last saw the deceased alive on July 16, 1957 , and that death occurred at _____ M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Md. DATE SIGNED 7/18 ACTUAL SIGNATURE [Signature] PHYSICIAN'S NAME (Type) J. W. Bird, M.D. Sandy Spring, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/21/57		22c. NAME OF CEMETERY OR CREMATORY Oak Grove		22d. LOCATION (City, town, or county) (State) Glenwood, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. HIGINBOTHOM				ADDRESS Ellicott City, Md.		24a. REC'D BY REGISTRAR JUL 22 1957 DATE	
24b. REGISTRAR'S SIGNATURE [Signature]							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

1957

4-2-57

<p>1. NAME OF DECEASED CLARK, JAMES H.</p>		<p>2. SEX Male</p>		<p>3. AGE 68</p>	
<p>4. DATE OF DEATH April 2, 1957</p>		<p>5. TIME OF DEATH 10:15 AM</p>		<p>6. PLACE OF DEATH Home</p>	
<p>7. OCCUPATION Retired</p>		<p>8. CAUSE OF DEATH Myocardial Infarction</p>		<p>9. MANNER OF DEATH Natural</p>	
<p>10. SIGNATURE OF PHYSICIAN J. H. Smith</p>		<p>11. SIGNATURE OF DECEASED (Blank)</p>		<p>12. SIGNATURE OF WITNESS J. H. Smith</p>	
<p>13. SIGNATURE OF REGISTRAR J. H. Smith</p>		<p>14. SIGNATURE OF DECEASED (Blank)</p>		<p>15. SIGNATURE OF WITNESS J. H. Smith</p>	

BUREAU V. S.

JUL 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07525

CERTIFICATE OF DEATH

07528

Reg. Dist. No.

19 1

1. PLACE OF DEATH o. COUNTY HOWARD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b 5 Wks.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TAYLOR MANOR HOSP				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto.			
3. NAME OF DECEASED (Type or print) NORMANDA. First Middle Last				4. DATE OF DEATH Month 7 Day 5 Year 1957			
5. SEX M.		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 9, 1889	
9. AGE (In years last birthday) yrs. 68		IF UNDER 1 YEAR Months 7 Days 5 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tavern Owner Own		10b. KIND OF BUSINESS OR INDUSTRY Own	
11. BIRTHPLACE (State or foreign country) Va.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Harvey Clarke				14. MOTHER'S MAIDEN NAME Emma Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs Anna Clarke				Address 1023 Wildwood Pkwy			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis, cerebral senescence (c) Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 334x						INTERVAL BETWEEN ONSET AND DEATH 72 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-19 , 19 56 , to 7-5 , 19 57 , that I last saw the deceased alive on 7-5 , 19 57 , and that death occurred at 6:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Irving J. Taylor M.D.				ADDRESS (Street, city, or town, state) Taylor Manor Hospital			
PHYSICIAN'S NAME (Type) IRVING J. TAYLOR				DATE SIGNED 7-5-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF Jul. 8/57		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Woodlawn MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke, Funeral Dir.				ADDRESS 4101 Edmondson Ave		24a. REC'D BY REGISTRAR DATE 7/8/57	
				24b. REGISTRAR'S SIGNATURE J. E. Laughery			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

BUREAU V. 2

JUL 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07524

Reg. Dist. No. 215

07526

1. PLACE OF DEATH a. COUNTY Howard MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Howard c. LENGTH OF STAY IN 1b New Rt. 29 Montgomery Co. Line d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2 mile So. Scaggsville				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Pennsylvania b. COUNTY Baltimore York c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Murrysville, (Rural) (Delivery #2) d. STREET ADDRESS 12 Maxwell Ct. Box 72-B e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) ROBERT KLINE EYLER First Middle Last				4. DATE OF DEATH July 25 19 57 Month Day Year											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 20, 1937		9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U S Navy				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy				11. BIRTHPLACE (State or foreign country) Baltimore, Md				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Edward Robinson EYLER						14. MOTHER'S MAIDEN NAME Mildred Kline									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (Current)				16. SOCIAL SECURITY NO. 215-34-1269				17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Fractures of Skull, Haw, Rt. Leg DUE TO (b) 823X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH Instant			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car ran off road and struck end of bridge											
20c. TIME OF INJURY Month, Day, Year Hour a. m. 2 AM p. m. 7-25-57 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway				20f. (City or town) 2 mile S. of Scaggsville (County) Howard (State) Md					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Frank E Shipley</i> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED			
EXAMINER'S NAME (Type) Frank E. Shipley M D						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Howard G. 7-25-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 29 Jul. 1957		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery				22d. LOCATION (City, town, or county) Arlington, Virginia (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.A. Pumphrey</i> ADDRESS R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md						24a. REC'D BY REGISTRAR DATE 7-26-57				24b. REGISTRAR'S SIGNATURE <i>Mary E. Parrelly</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use. File pages 1 and 2 with the registrar for burial, cremation, or removal.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE IN
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 29 1957

RECEIVED

07527

CERTIFICATE OF DEATH

Reg. Dist. No.

190

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(RURAL) ELKRIDGE 27</u> 76yrs.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 (RURAL) ELKRIDGE 27</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MONTGOMERY ROAD</u>				d. STREET ADDRESS <u>1 MONTGOMERY ROAD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA LOUISE Hobbs</u>				4. DATE OF DEATH Month Day Year <u>JULY 4, 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 22, 1880</u> 76 yrs.		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>August Nicolai</u>				14. MOTHER'S MAIDEN NAME <u>MARY WEHLAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Joseph E. Hobbs, ELKRIDGE 27, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Heart Disease recurrent</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chr Myocarditis</u> DUE TO <u>Decompensation</u> (c) <u>General Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>1 yr</u> <u>2 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 2, 1956</u> to <u>July 4, 1957</u> , that I last saw the deceased alive on <u>July 4, 1957</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B B Brumbaugh</u> M.D.				ADDRESS (Street, city or town, state) <u>3609 main st ElkrIDGE 27 Md</u>			
DATE SIGNED <u>7/9/57</u>							
PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons, Catonsville 28, Md.</u>				ADDRESS <u>Catonsville 28, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 9 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. E. Hughes</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF CORONER		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS	
22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS	
28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS	
34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS	
40. SIGNATURE OF WITNESS		41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS	
43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS		51. SIGNATURE OF WITNESS	
52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS	
55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS	
58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS	
64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS		66. SIGNATURE OF WITNESS	
67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS	
70. SIGNATURE OF WITNESS		71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS	
79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS		81. SIGNATURE OF WITNESS	
82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS	
88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS	
94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS	
100. SIGNATURE OF WITNESS		101. SIGNATURE OF WITNESS		102. SIGNATURE OF WITNESS	

BUREAU V. S.

JUL 9 1957

RECEIVED

INSTRUCTIONS

1. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07526

07528 CERTIFICATE OF DEATH

Item 8 FilmG218 7-18-57 et

Reg. Dist. No. 190

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Howard		MARYLAND		STATE Maryland		COUNTY Howard	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Elkridge		LENGTH OF STAY (in this place) 25 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elkridge			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1912 St. Augustine Ave.				STREET ADDRESS (If rural give location) 1912 St. Augustine Ave.			
3. NAME OF DECEASED (Type or Print) John O. Merson (First) (Middle) (Last)				4. DATE OF DEATH July 13, 1957 (Month) (Day) (Year)			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH October 25, 1898		9. AGE last birthday 58 yrs.		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Federal Tin		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) No		16. SOCIAL SECURITY NO. 215-10-2857		17. INFORMANT & ADDRESS Mary A. Merson 1912 St. Augustine Ave.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
527.1 IMMEDIATE CAUSE (A) Cardio-Vascular Decompensation						INTERVAL BETWEEN ONSET AND DEATH 1 month	
ANTECEDENT CAUSE(S) DUE TO (B) Pulmonary Emphysema						2 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 4/3/53		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 7/13/57, and that death occurred at 8:00 A.M. from the causes and on the date stated above.							
SIGNATURE Frank E. Shipley, M.D.				DATE SIGNED 7/14/57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 16, 1957		NAME OF CEMETERY OR CREMATORY Meadowridge		LOCATION (City, town, or county) Dorsey, Howard, Maryland	
24. REC'D BY REGISTRAR JUL 16 1957		REGISTRAR'S SIGNATURE E. Bird Williams		25. FUNERAL DIRECTOR'S SIGNATURE Ambrose & Inc. 1328 Sulphur Sp. Rd			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

NAME: HOWARD
 RESIDENCE: Evington
 1918 St. Augustine Ave.
 DATE OF DEATH: July 15, 1957
 PLACE OF DEATH: Baltimore, Maryland

SEX: Male
 RACE: White
 BIRTH: October 23, 1907
 PLACE OF BIRTH: Maryland
 OCCUPATION: Unknown

CAUSE OF DEATH: Myocardial Infarction
 ICD-9 CODE: 410.91
 MARY A. PERSON 1919 St. Augustine Ave.

Physician's Signature: [Signature]
 Date: July 16, 1957
 Registrar's Signature: [Signature]
 Date: July 16, 1957

BUREAU V. E.

JUL 16 1957

RECEIVED

July 16, 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07529

CERTIFICATE OF DEATH

07529

Reg. Dist. No.

196

1. PLACE OF DEATH a. COUNTY Howard				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City Rural				d. STREET ADDRESS 39 Allview Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRIETTA RITZENTHALER				4. DATE OF DEATH Month July Day 5 Year 1957									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-14-1863		9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) Norwalk Ohio				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jacob Urban				14. MOTHER'S MAIDEN NAME ?									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Richard Germann, Ellicott City, Md				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Clarksville, Maryland		(County) Howard		(State) Md	
21. I certify that I attended the deceased from 10/6/1956 , to 7/5/1957 , that I last saw the deceased alive on 7/5/1957 , and that death occurred at 11:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Charles S. Whitaker, M.D. PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D. Clarksville, Maryland 7/6/57													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-8-57		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd				22d. LOCATION (City, town, or county) (State) Ellicott City, Md			
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.						24a. REC'D BY REGISTRAR JUL 9 1957		24b. REGISTRAR'S SIGNATURE J. E. Dougherty					

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		45		1912-11-15		Baltimore		Maryland		United States			
MARRIAGE		SINGLE		MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
None		None		None		None		None		None		None		None	
OCCUPATION		PROFESSION		INDUSTRY		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
None		None		None		1957-11-15		Baltimore		Maryland		United States			
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
None		None		None		None		None		None		None		None	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF		SIGNATURE OF	
None		None		None		None		None		None		None		None	

BUREAU V. 2

111 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07528

07530

CERTIFICATE OF DEATH

Reg. Dist. No.

192

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Friendship				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM WELLING SMALLWOOD				4. DATE OF DEATH Month Day Year July 4 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1899		9. AGE (In years last birthday) yrs. 58	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Sheriff		10b. KIND OF BUSINESS OR INDUSTRY Sheriff Dept.		11. BIRTHPLACE (State or foreign country) Dayton, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William W. Smallwood				14. MOTHER'S MAIDEN NAME Florence Iglehart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-34-3241		17. INFORMANT Address Mrs. Ada Smallwood West Friendship, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease with auricular fibrillation							INTERVAL BETWEEN ONSET AND DEATH 3 mins.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from January 1, 1955 , to July 4, 1957 , that I last saw the deceased alive on June 21, 1957 , and that death occurred at 6:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Charles S. Whitaker M.D. M.D.				PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D. Clarksville, Maryland 7/4/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/6/57		22c. NAME OF CEMETERY OR CREMATORY St. Marks		22d. LOCATION (City, town, or county) (State) Highland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham				ADDRESS Ellicott City, Md.		24a. REC'D BY REGISTRAR JUL 8 1957	
				24b. REGISTRAR'S SIGNATURE Allice Kelly			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15, 1910		Baltimore, Md.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
Jan 20, 1957		10:00 AM		Home		Dr. Smith		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]		[Seal]		[Seal]	

BUREAU V. S.

JUL 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07531

CERTIFICATE OF DEATH

Reg. Dist. No.

07529
194

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Simpsonville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Simpsonville</u> x 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Rt # 32</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>MARIE</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>July</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 4 1931</u>	
9. AGE (In years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u>25</u> Days <u>25</u> Hours <u>25</u> Min.		IF UNDER 24 HRS. Months <u>25</u> Days <u>25</u> Hours <u>25</u> Min.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Henry Jenson</u>				14. MOTHER'S MAIDEN NAME <u>Roberta Bromgoad</u>			
15. WAS DECEASED EVER IN U. S. A. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Henry Jenson - Simpsonville, Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA BILATERAL</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>490X</u> (b) <u>VIRAL GASTRITIS, SEVERE</u> DUE TO (c) <u>490X</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>1 wk.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ANXIETY NEUROSIS (R/C CROWNSVILLE STATE HOSP.)</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>OCT.</u> 19 <u>56</u> , to <u>JULY</u> 19 <u>57</u> , that I last saw the deceased alive on <u>JULY 26</u> 19 <u>57</u> , and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald E. Fisher</u> M.D.				ADDRESS (Street, city or town, state) <u>Edelbert Ct. Md.</u>			
DATE SIGNED <u>2-26-57</u>							
PHYSICIAN'S NAME (Type) <u>DONALD E. FISHER M.D.</u>							
22a. BURIAL, CREMATION, or other disposition (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/29/57</u>		<u>Hopkins Chapel.</u>		<u>Highland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swarden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>Marie Whitaker</u>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint, illegible markings.

BUREAU V. S.

AUG 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07530

Reg. Dist. No. 190

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A A			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 210 Bertram Circle, Glenburnie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 144				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ERNEST Middle EARL Last SWANSON				4. DATE OF DEATH Month July Day 1 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 27, 1902	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 5 Days 1 Hours 57 Min.		IF UNDER 24 HRS. Months 5 Days 1 Hours 57 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Penna	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME John Swanson				14. MOTHER'S MAIDEN NAME Jennie A. Bolyard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW 1 217-10-1535		17. INFORMANT James Swanson, Glenburnie, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 322.0 Acute alcoholism DUE TO Conditions, if any, which gave rise to immediate cause (b) 322.0 (c), stating the underlying cause lost. 322.0 DUE TO (c) 322.0				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Paul F. Guerin				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul F. Guerin				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-57		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham				24a. REC'D BY REGISTRAR JUL 5 1957			
ADDRESS Ellicott City, Md				24b. REGISTRAR'S SIGNATURE J. E. Laughery			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JUL 5 1957

RECEIVED

Frank J. Jones

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

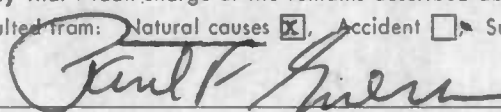
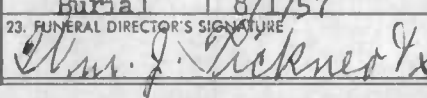
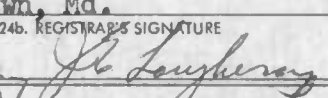
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or reinterment.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07531

Reg. Dist. No. 190

1. PLACE OF DEATH a. COUNTY Howard MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City (Clarksville)			c. LENGTH OF STAY IN 1b X/1 Ellicott City (Clarksville)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Haylases Farm - Sheppard Lane			d. STREET ADDRESS Haylases Farm - Sheppard Lane		
3. NAME OF DECEASED (Type or print) First CAROLYN Middle R. Last THOMAS			4. DATE OF DEATH Month July Day 29 Year 19 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1896		9. AGE (In years last birthday) 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY self employed	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? ville
13. FATHER'S NAME Ripperger			14. MOTHER'S MAIDEN NAME Mary E. -		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Excluded		16. SOCIAL SECURITY NO. no	17. INFORMANT Mr. Harry G. Thomas, Jr. - Sheppard Lane, Clarks-		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE 			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 7/29/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/1/57	22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE 			24a. REC'D BY REGISTRAR Jul 31 1957		
ADDRESS Wm. J. Dickner & Sons - Baltimore			24b. REGISTRAR'S SIGNATURE 		

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death	
John Doe		Male		35		White		July 2, 1957	
Place of Birth		Usual Residence		Cause of Death		Manner of Death		Occupation	
New York City		New York City		Heart Disease		Natural		Teacher	
Physician		Medical Examiner		Signature		Signature		Signature	
Dr. J. Smith		Dr. J. Smith		Dr. J. Smith		Dr. J. Smith		Dr. J. Smith	

John Doe

BUREAU OF HEALTH

JUL 31 1957

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